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**Written Testimony**
**Western Hemisphere Subcommittee**

**I'd like to thank Chairman Burton for holding the hearings, and Ranking Member Menendez for inviting me to testify. I look forward to discussing the issues with all members of the subcommittee.**

Lutheran Medical Center's journey to linking public health in the Caribbean to public health in the Caribbean-American communities of central Brooklyn began with the establishment of the Caribbean-American Family Health Center in East Flatbush. Lutheran Medical Center, a 476-bed teaching hospital serving southwest and Central Brooklyn, operates a federally funded ambulatory network of nine outpatient clinics serving 90,000 patients. The Caribbean American Family Health Center is geographically and culturally unique within and outside of the network. Its beginnings reflect the uniqueness of the population served, and of the Center itself.

To be sure, the Caribbean-American community in central Brooklyn that is served by the Center has many characteristics in common with other high health risk neighborhoods - large minority and immigrant groups, high rates of poverty and unemployment, poor housing, poor sanitation, high rates of violence, and of course, lack of adequate medical care. However, we decided early on to focus on what was unique about this community, rather than what was common.

In this spirit, The Center was born of a close collaboration with the Caribbean Women's Health Association, a community-based organization that continues to provide support services of the highest quality in central Brooklyn. Lutheran recognized the value of Caribbean Women's Health Association's existing relationships with and understanding of the target community. We worked with Caribbean Women's Health Association to identify and involve community residents to help plan and develop programs. We developed an advisory committee of community stakeholders - from faith based community leaders to barbershop owners to community residents who worked in Manhattan as domestic assistants - to ensure that our plan, programs and messages were culturally competent, linguistically appropriate and educationally sound.

From the start, a keystone of our program design was to generate a network of partners from the community. We engaged other community-based organizations, faith-based organizations and the full spectrum of community leadership and safety-net organizations in our center. We had buy-in from every sector of the community. That network still exists as a formal structure, almost ten years later, as the Brooklyn Alliance to Strengthen the Safety Net.

Our outreach, education and marketing strategies were designed around the community to be served. We knew that our target population had its own newspapers, radio stations, barbershops and a host of informal networks of communication. These were the channels that we chose to spread our initial message.

Soon after opening, we expanded our hours to include evenings and weekends to accommodate community residents who work as live-in domestic assistants, and cannot access services during the business day. We recognized that many people living in the Center's service area were uninsured or underinsured. In response, we brought facilitated enrollers from managed care companies to the site, and continue to connect eligible consumers to subsidized insurance products including Child Health Plus.

Another key aspect of our approach in opening the center was to hire a staff reflective of the patients they would be serving. We recognized early on that if we were going to be effective stewards of the health of this unique and vital community, we would need a staff in place that understood the history, cultural norms, and both the formal and informal healthcare structures in play. We needed, and still need, a staff that understands the attitudes, beliefs and behaviors of Caribbean-Americans when it comes to health, illness, and utilization of health care services.

Immediately, we began seeing many patients who were in New York on vacation, visiting family, and many immigrants to the United States. At the same time, we conducted an informal study of our patients' presenting and persistent health issues. What we noticed was not surprising - we were seeing many patients with heart disease, cancer, diabetes, respiratory diseases and an alarming number of people living with HIV/AIDS. We immediately recognized the danger of an internationally mobile population disproportionately affected by HIV/AIDS, and decided to do something about it.

When we saw the announcement for federal funding available to create a "Twinning" program to connect and mutually strengthen HIV/AIDS treatment infrastructures in the Caribbean and in the United States, we knew opportunity was knocking, and we applied for and received the grant.

We decided to focus on Trinidad & Tobago in particular because so many of our patients come from that island, and because HIV/AIDS has had a particularly devastating impact there. The World Health Organization reports that the number of reported AIDS cases in Trinidad and Tobago increased by 200% from 1997 to 1999. The number of cases in Trinidadians under age 19 increased by almost 300% during that same period of time. When we prepared our grant proposal in 2003, the average time from AIDS diagnosis to death was 13 months, indicating extremely late entry into care.

As such, we decided that one of the primary goals of our program would be to strengthen HIV/AIDS treatment capacity in Trinidad & Tobago so that patients would not have to travel to the United States for treatment. To that end, we partnered with the largest HIV/AIDS treatment center in Trinidad & Tobago, and took a look at their practice from top to bottom, or from a patient's eyes, from door-to-door. Among the many practice improvements we designed and implemented were a centralized appointment system, a uniform medical records system, and an on-call system. We installed and networked computers, and provide ongoing technical support and training on the use of the new

technology. We brought a team of providers and support staff from Trinidad and Tobago to Lutheran, so that they could observe, learn and ask questions, and take what they learned back to the Caribbean.

In addition, the Caribbean-American Family Health Center's Medical Director is also the Medical Director at the Cyril Ross Nursery, an institution that provides healthcare and support services for children living with HIV/AIDS in Trinidad and Tobago. Many of his adult Caribbean patients who would have had to come to New York to see their doctor and receive medication now receive the same level of care at home, thanks to the government of Trinidad & Tobago's initiative to provide free medication to people living with HIV/AIDS.

Though we have been successful, the path has not been without its challenges and obstacles. We have faced communication challenges presented by geographic distance, differences in cultural values, beliefs, norms and organizational priorities. We have faced the very basic challenge of limited human and material resources, both in the Caribbean and here in the United States. We have learned that the most important piece of advice we can pass on to others interested in creating similar programs is simply this; be flexible. Have as few assumptions as possible, and be prepared for the wonderful differences that are at the heart of our notions of diversity to cause you considerable frustration.

The funding that Congress has thus far allocated to US government agencies working in the Caribbean is having an impact. I urge you to continue funding these vital programs. With the ease of travel between the United States and the Caribbean and other points throughout the world, the globe is shrinking. It is now abundantly clear that a public health issue in the Caribbean quickly translates to a public health issue in the United States, and vice versa. This should not stop with HIV/AIDS, just one of a host of chronic conditions that disproportionately affect both the Caribbean itself, and Caribbean populations in the United States. The Twinning program can be used as a model, and extended to a broad spectrum of other health issues, whether heart disease, cancer, asthma or diabetes.

In partnership with Congress and all US government agencies working in the Caribbean, we must continue to strive to create partnerships that reduce duplicative efforts, breed innovation and efficiency, attack disparities of any kind, and maximize the impact of each and every dollar spent to the greatest possible mutual benefit of the United States and the Caribbean.